## MEDICARE LINE LEVEL REMARK CODES

Remark codes must be used to relay service-specific Medicare informational messages that cannot be expressed with a reason code. Medicare remark codes are maintained by HCFA. As with the CAS reason codes, Medicare contractors are also prohibited from use of local remark codes.

Remark codes and messages must be used whenever they apply. Although contractors may use their discretion to determine when certain remark codes apply, they do not have discretion as to whether to use an applicable remark code in a remittance notice. A limitation of liability message (M25-M27) must be used where applicable. An unlimited number of Medicare line level remark codes may be entered as warranted in an X12 835 RA; there is a limit of 5 line level remark code entries in a NSF RA and on a standard paper remittance notice.

### Line Level Remark Codes

| Code Value | Description |
|---|---|
| M1 | X-ray not taken within the past 12 months or near enough to the start of treatment. |
| M2 | Not paid separately when the patient is an inpatient. |
| M3 | Equipment is the same or similar to equipment already being used. |
| M4 | This is the last monthly installment payment for this durable medical equipment. |
| M5 | Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed. |
| M6 | You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period. |
| M7 | No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price. |
| M8 | We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen. |
| M9 | This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement. |
| M10 | Equipment purchases are limited to the first or the tenth month of medical necessity. |
| M11 | DME, orthotics and prosthetics must be billed to the DME carrier who services the beneficiary's zip code. |
| M12 | Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim. |
| M13 | No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code. |
| M14 | No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection. |
| M15 | Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. |

M16 Please see the letter or bulletin of (date) for further information. [Note: Contractor must enter the date of the letter/bulletin.]

M17 Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.

M18 Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.

M19 Oxygen certification/recertification (HCFA-484) is incomplete or is required.

M20 HCPCS needed.

M21 Claim for services/items provided in a home must indicate the place of residence.

M22 Claim lacks the number of miles traveled.

M23 Invoice needed for the cost of the material or contrast agent.

M24 Claim must indicate the number of doses per vial.

M25 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- o If you did not know, and could not have reasonably been expected to know, that we would not pay for this service: or
- o If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(l) of the Social Security Act and 42CFR411.408
. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.

M27 The beneficiary has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the beneficiary's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

M28 This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.

M29 Claim lacks the operative report.

M30 Claim lacks the pathology report.
M31 Claim lacks the radiology report.
M32 This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.

M33 Claim lacks the UPIN of the ordering/referring or performing physician, physician assistant, nurse practitioner or clinical nurse specialist, or the UPIN is invalid. (Substitute NPI for UPIN when effective.)
M34 Claim lacks the CLIA certification number.
M35 Claim lacks pre-operative photos or visual field results.
M36 This is the 11th rental month. We cannot pay for this until you indicate that the beneficiary has been given the option of changing the rental to a purchase.
M37 Service not covered when the beneficiary is under age 35.
M38 The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay.
M39 The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
M40 Claim must be assigned and must be filed by the practitioner's employer.
M41 We do not pay for this as the patient has no legal obligation to pay for this.
M42 The medical necessity form must be personally signed by the attending physician.
M43 Payment for this service previously issued to you or another provider by another Medicare carrier/intermediary.
M44 Incomplete/invalid condition code.
M45 Incomplete/invalid occurrence codes and dates.
M46 Incomplete/invalid occurrence span code and dates.
M47 Incomplete/invalid internal or document control number.
M48 Medicare payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M49 Incomplete/invalid value code(s) and/or amount(s).
M50 Incomplete/invalid revenue code(s).
M51 Incomplete/invalid, procedure code(s) and/or rates, including “not otherwise classified” or “unlisted” procedure codes submitted without a narrative description.
(Add to message for carriers only: Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.)
M52 Incomplete/invalid “from” date(s) of service.
M53 Did not complete or enter the appropriate number (one or more) of days or units(s) of service.
M54 Did not complete or enter the correct total charges for services rendered.

M55 Medicare does not pay for self-administered anti-emetic drugs that are not administered with a Medicare-covered oral anti-cancer drug.
M56 Incomplete/invalid payer identification.
M57 Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)
M58 Please resubmit the claim with the missing/correct information so that it may be processed.
M59 Incomplete/invalid "to" date(s) of service.
M60 Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form or in an approved format.
M61 We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62 Incomplete/invalid treatment authorization code.
M63 Medicare does not pay for more than one of these on the same day.
M64 Incomplete/invalid other diagnosis code.
M65 One interpreting physician can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
M66 Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
M67 Incomplete/invalid other procedure code(s) and/or date(s).
M68 Incomplete/invalid attending or referring physician identification.
M69 Paid at the regular rate as you did not submit documentation to justify modifier 22.
M70 NDC code submitted for this service was translated to a HCPCS code for Medicare processing, but please continue to submit the NDC on future claims for this item.
M71 Total payment reduced due to overlap of tests billed.
M72 Did not enter full 8-digit date (MM/DD/CCYY).
M73 The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.
M74 This service does not qualify for a HPSA bonus payment.
M75 Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.
M76 Incomplete/invalid patient's diagnosis(es) and condition(s).
M77 Incomplete/invalid place of service(s).
M78 Did not complete or enter accurately an appropriate HCPCS modifier(s).
M79 Did not complete or enter the appropriate charge for each listed service.
M80 We cannot pay for this when performed during the same session as a previously processed service for the beneficiary.
M81 Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.
M82 Service is not covered when beneficiary is under age 50.
M83 Service is not covered unless the beneficiary is classified as at high risk.
M84 Old and New HCPCS cannot be billed for the same date of service.
M85 Subjected to review of physician evaluation and management services.

M86 Service denied because payment already made for similar procedure within set time frame.
M87 Claim/service(s) subjected to CFO-CAP prepayment review..
M88 We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89 Not covered more than once under age 40.
M90 Not covered more than once in a 12 month period.
M91 Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92 Services subjected to review under the Home Health Medical Review Initiative.
M93 Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94 Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95 Services subjected to Home Health Initiative medical review/cost report audit.
M96 The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97 Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98 Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99 Incomplete/invalid/missing Universal Product Number.
M100 We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101 Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102 Service not performed on equipment approved by the FDA for this purpose.
M103 Information supplied supports a break in therapy. However, the medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104 Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the Medicare fee schedule for this item or service.
M105 Information supplied does not support a break in therapy. The medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M106 Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the Medicare fee schedule for this item or service.
M107 Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.

M108 Must report the PIN of the physician who interpreted the diagnostic test. (Substitute NPI for PIN when effective.)

M109 We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.

M110 Missing/invalid provider number for the provider from whom you purchased interpretation services. (Substitute NPI for provider number when effective.)

M111 We do not pay for chiropractic manipulative treatment when the beneficiary refuses to have an x-ray taken.

M112 The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.

M113 Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.

M114 This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.

M115 This item is denied when provided to this patient by a nondemonstration supplier.

M116 Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided to this patient by a nondemonstration supplier. If you would like more information regarding this project, you may phone 1-888-289-0710.

M117 Not covered unless supplier files an electronic media claim (EMC).

M118 Letter to follow containing further information.

M119 National Drug Code (NDC) needed.

M120 Lacks UPIN of the substituting physician who furnished the service(s) under a reciprocal billing or loco tenens arrangement. (Substitute NPI for UPIN when effective.)

M121 and following. Reserved for future use.

## MEDICARE CLAIM LEVEL REMARKS CODES

A maximum of 5 of these claim level Medicare Inpatient Adjudication (MIA) and 5 of these claim level Medicare Outpatient Adjudication (MOA) remarks codes may be used per claim. See the Medicare 835 Implementation Guides. Insert these codes in the space for semantics 5 or 20-23 of the MIA segment or semantics 3-7 of the MOA segment as applicable. Previously established MIA/MOA semantic codes [MIA01, 03-04, 06-19 and 24, and MOA01-02 and 08-09] are not impacted by this instruction and must continue to be used as indicated in the Medicare Part A 835 Implementation Guide. MIA01, 03-04, 06-19 and 24, and MOA01-02 and 08-09 as listed in the Part A 835 Implementation Guide do not apply to the NSF, but individual Medicare MIA/MOA remarks codes listed in this document must also be used in the NSF and the standard paper remittance notice. See NSF and standard paper remittance notice specifications for use of Medicare MIA/MOA remarks codes in NSF and paper RAs.

Medicare MIA/MOA remarks codes are used to convey appeal information and other claim-specific information that does not involve a financial adjustment. As with the 835/NSF reason and Medicare line level remarks codes, Medicare contractors are also prohibited from use of local MIA/MOA codes.

An appropriate appeal, limitation of liability or other message must be used whenever applicable. Although contractors have discretion to determine when certain remarks codes and messages apply, they do not have discretion as to whether to use applicable codes and messages.

| Code Value | Description |
|---|---|
| MA01 | (Initial Part B determination, carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late.<br><br>(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)<br><br>(NOTE: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.) |
| MA02 | (Initial Part A determination)--If you do not agree with this determination, you have the |

right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

MA03 (Hearing)--If you do not agree with the Medicare approved amounts and $100 or more is in dispute (less deductible and coinsurance) , you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been reviewed/reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

MA05 Incorrect admission date, patient status or type of bill entry on claim. (NOTE: See MA30, MA40 and MA43 also.)

MA06 Incorrect beginning and/or ending date(s) on claim.

MA07 The claim information has also been forwarded to Medicaid for review.

MA08 You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

MA09 Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.

MA10 The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.

MA11 Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.

MA12 You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).

MA13 You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (patient responsibility) group code.

MA14 Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.

MA15 Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.

MA16 The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.

MA17 We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.

MA18 The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

MA19 Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.

MA20 SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.

MA21 SSA records indicate mismatch with name and sex.

MA22 Payment of less than $1.00 suppressed.

MA23 Demand bill approved as result of medical review.

MA24 Christian Science Sanitorium/ SNF bill in the same benefit period.

MA25 A patient may not elect to change a hospice provider more than once in a benefit period.

MA26 Our records indicate that you were previously informed of this rule.

MA27 Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.

MA28 Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.

MA29 Incomplete/invalid provider name, city, state, and zip code.

MA30 Incomplete/invalid type of bill.

MA31 Incomplete/invalid beginning and ending dates of the period billed.

MA32 Incomplete/invalid number of covered days during the billing period.

MA33 Incomplete/invalid number of noncovered days during the billing period.

MA34 Incomplete/invalid number of coinsurance days during the billing period.

MA35 Incomplete/invalid number of lifetime reserve days.

MA36 Incomplete/invalid patient's name.

MA37 Incomplete/invalid patient's address. (Note: When used, a Medicare contractor must verify that an address, with city, State, and zip code, and a phone number are present.)

MA38 Incomplete/invalid patient's birthdate.

MA39 Incomplete/invalid patient's sex.

MA40 Incomplete/invalid admission date.

MA41 Incomplete/invalid type of admission.

MA42 Incomplete/invalid source of admission.
MA43 Incomplete/invalid patient status.
MA44 No appeal rights on this claim. Every adjudicative decision based on Medicare law.
MA45 As previously advised, a portion or all of your payment is being held in a special account.
MA46 The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.

MA47 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment
MA48 Incomplete/invalid name and/or address of responsible party or primary payer .
MA49 Incomplete/invalid six-digit Medicare provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50 Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51 Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52 Did not enter full 8-digit date (MM/DD/CCYY for paper form or CCYY/MM/DD for electronic format).
MA53 Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
MA54 Physician certification or election consent for hospice care not received timely.
MA55 Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57 Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58 Incomplete release of information indicator.
MA59 The beneficiary overpaid you for these services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60 Incomplete/invalid patient's relationship to insured.
MA61 Did not complete or enter correctly the patient's social security number or health insurance claim number.
MA62 Telephone review decision
MA63 Incomplete/invalid principal diagnosis code.

MA64 Our records indicate that Medicare should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65 Incomplete/invalid admitting diagnosis.
MA66 Incomplete/invalid principal procedure code and/or date.
MA67 Correction to a prior claim.
MA68 We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PAYERID of the insurer to assure correct and timely routing of the claim.
MA69 Incomplete/invalid remarks.
MA70 Incomplete provider representative signature.
MA71 Incomplete/invalid provider representative signature date.
MA72 The beneficiary overpaid you for these assigned services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the beneficiary on this notice.
MA73 Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74 This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75 Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.
MA76 Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.
MA77 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the beneficiary's payment less the total of Medicare and other payer payments and the amount shown as patient responsibility on this notice.
MA78 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the Medicare allowed amount total and the amount paid by the beneficiary.
MA79 Billed in excess of interim rate.
MA80 Informational notice. No payment issued for this claim with this notice. Medicare payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81 Our records indicate neither a physician or supplier signature is on the claim or on file.
MA82 Did not complete or enter the correct physician/supplier's Medicare billing number/NPI and/ or billing name, address, city, state, zip code, and phone number.
MA83 Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
MA84 Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.

MA85 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the Payer ID when effective.

MA86 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group or policy number of the insured.

MA87 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the correct insured's name.

MA88 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and/or telephone number.

MA89 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.

MA90 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employment status code of the primary insured.

MA91 This determination is the result of the appeal you filed.

MA92 Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information.
(NOTE: Carriers must also add: Refer to the HCFA-1500 instructions on how to complete MSP information.)

MA93 Non-PIP claim.

MA94 Did not enter the statement “Attending physician not hospice employee” on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.

MA95 A “not otherwise classified” or “unlisted” procedure code(s) was billed, but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.

MA96 Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.

MA97 Claim rejected. Does not contain the Medicare Managed Care Demonstration contract number, however, the beneficiary is enrolled in a Medicare managed care plan.

MA98 Claim rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.

MA99 Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.

MA100 Did not complete or enter accurately the date of current illness, injury or pregnancy.

MA101 A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.

MA102 Did not complete or enter accurately the referring/ordering/supervising physician's/physician assistant’s, nurse practitioner’s, or clinical nurse specialist’s name and/or UPIN. (Substitute “NPI” for “UPIN” when effective.)

MA103 Hemophilia Add On

MA104 Did not complete or enter accurately the date the patient was last seen and/or the UPIN of the attending physician. (Substitute "NPI" for "UPIN" when effective.)

MA105 Missing/invalid provider number for this place of service. Place of service shown as 21, 22, or 23 (hospital). (Substitute "NPI" for provider number when effective.)

MA106 PIP claim

MA107 Paper claim contains more than three separate data items in field 19.

MA108 Paper claim contains more than one data item in field 23.

MA109 Claim processed in accordance with ambulatory surgical guidelines.

MA110 Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.

MA111 Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.

MA112 Our records indicate that the performing physician/supplier/practitioner is a member of a group practice; however, you did not complete or enter accurately their carrier assigned individual and group PINs. (Substitute "NPI" for "PIN" when effective.)

MA113 Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.

MA114 Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished. (Substitute "NPI" for "PIN" when effective.)

MA115 Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered. (Substitute "NPI" for "PIN" when effective.)

MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.

MA117 This claim has been assessed a $1.00 user fee.

MA118-119 Reserved for future use

MA120 Did not complete or enter accurately the CLIA number.

MA121 Did not complete or enter accurately the date the X-Ray was performed.

MA122 Did not complete or enter accurately the initial date "actual" treatment occurred.

MA123 Your center was not selected to participate in this study, therefore, we cannot pay for these services.

MA124 Processed for IME only.

MA125 Per legislation governing this program, payment constitutes payment in full.

MA126-127 Reserved for future use

MA128 Did not complete or enter accurately the six digit FDA approved, identification number.

MA129 This provider was not certified for this procedure on this date of service. Effective 1/1/98, we will begin to deny payment for such procedures. Please contact _____ to correct or obtain CLIA certification. (Claim processor must insert the name and phone number of the State Agency to be contacted.)

MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

MA131 and higher Reserved for future use